STATE OF NEW YORK
DEPARTMENT OF HEALTH
P.O. Box 11729
Albany, NY 12211

Notice of Decision

Decision Date: January 4, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000023156

[redacted]

On December 7, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's October 5, 2017 eligibility determination notice.

The enclosed Decision, rendered after that hearing, is issued by the Appeals Unit of NY State of Health.

If you have questions about your Decision, you can contact us by:

- Calling the Customer Service Center at 1-855-355-5777
- Sending Mail to:

  NY State of Health Appeals
  P.O. Box 11729
  Albany, NY 12211

- Sending a Fax to 1-855-900-5557

When contacting NY State of Health about your appeal and/or the Decision, please refer to the Appeal Identification Number at the top of this notice.

Legal Authority

We are sending you this notice in accordance with 45 Code of Federal Regulation (CFR) §155.545.

If you need this information in a language other than English or you need assistance reading this notice, we can help you. Call 1-855-355-5777 (TTY - English: 1-800-662-1220) (TTY – Spanish: 1-877-662-4886).

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STATE OF NEW YORK
DEPARTMENT OF HEALTH
P.O. Box 11729
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Decision

Decision Date: January 4, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000023156

[redacted]

Issue

The issue presented for review by the Appeals Unit of NY State of Health is:

> Did New York State of Health (NYSOH) properly determine that you and your spouse were eligible to purchase a qualified health plan (QHP) at full cost, effective November 1, 2017?

Procedural History

On September 5, 2017, NY State of Health (NYSOH) issued a notice stating that it was time to renew your health insurance for the upcoming coverage year. That notice stated that, based on information from federal and state sources which indicated that your annual household income was over $64,080.00, that you and your spouse were eligible for a full cost QHP. The notice also stated that you needed to update your account by October 15, 2017. The eligibility was effective November 1, 2017.

On September 18, 2017, you updated your NYSOH attesting to an annual household income of $19,300.00. Also on that date, you uploaded proof of income.

On September 19, 2017, NYSOH issued a notice stating that the income in your application did not match what NYSOH had received from federal and state sources. The notice directed you to provide proof of income by October 3, 2017.

On September 23, 2017, NYSOH issued a notice stating that the documentation that you provided did not confirm the information in your application. The notice directed you to provide proof of income by October 18, 2017.

On October 4, 2017, you uploaded proof of income.

On October 5, 2017, NYSOH issued an eligibility determination notice stating that you and your spouse were eligible to enroll in a QHP at full cost based on an annual household income of $64,702.00. The eligibility determination was effective November 1, 2017.

Also on October 5, 2017, you spoke with NYSOH's Account Review Unit and requested an appeal regarding the lack of financial assistance you and your spouse were determined eligible to receive.

On December 7, 2017, you had a telephone hearing with a Hearing Officer from the NYSOH's Appeals Unit. The record was developed during the hearing and closed at the end of the hearing.

Findings of Fact

A review of the record supports the following findings of fact:

1. You are applying for health insurance with financial assistance through NYSOH for yourself and your spouse.

2. According to your NYSOH account and your testimony, you plan on filing a 2017 federal income tax return, with the tax status of married and expect to claim no dependents on that return.

3. On October 4, 2017, you uploaded your 2016 federal income tax return.

4. According to NYSOH records, also on October 4, 2017, NYSOH determined your 2017 estimated annual household income was $64,702.00. You testified that this amount was inaccurate because it was based on your 2016 annual household income which was not the same as your expected 2017 annual household income.

5. The October 4, 2017 NYSOH eligibility determination listed your income as follows: taxable interest $14,000.00; deferred compensation distribution $5,300.00; tax exempt interest $3,819.00, ordinary dividends $9,794.00, tax refunds $808.00, capital gain $22,228.00 and qualified dividends $8,753.00 for a total of $64,702.00.

6. On October 5, 2017, NYSOH issued an eligibility determination notice stating that you and your spouse were eligible to enroll in a QHP at full cost based on an annual household income of $64,702.00. The eligibility determination was effective November 1, 2017.

7. NYSOH records reflect that your 2017 estimated annual household income was determined based on your earnings from your 2016 federal income tax return.

8. At the December 7, 2017 hearing, you testified that your expected 2017 annual household income was as follows: taxable interest $5,000.00; deferred compensation distribution $5,300.00; tax exempt interest $3,819.00, ordinary dividends $9,794.00, tax refund $11,939.00, and qualified dividends $8,753.00 for a total of $44,605.00.

9. Your application reflects that you do not intend to take any deductions on your 2017 tax return.

10. You reside in Suffolk County, New York.

11. You testified that you believe you and your spouse should be eligible for some form of financial assistance, including tax credits to reduce the overall cost of your monthly premium.

Conflicting evidence, if any, was considered and found to be less credible than the evidence noted above.

Applicable Law and Regulations

Advance Premium Tax Credit

Advance premium tax credit (APTC) are generally available to a person who is eligible to enroll in a qualified health plan (QHP) and (1) expects to have a household income between 138% and 400% of the applicable federal poverty level (FPL), (2) expects to file a tax return and claim a personal exemption deduction for a person who meets the eligibility requirements to enroll in a QHP, and (3) is not otherwise eligible for minimum essential coverage except through the individual market (*see* 45 CFR § 155.305(f), 42 CFR § 435.119(b), 42 CFR § 435.911(b)(1), 42 CFR § 435.603(d)(4)).

In an analysis of APTC eligibility, the determination is based on the FPL for the first day of the open enrollment period of the benefit year for which coverage is requested (45 CFR §§ 155.300(a), 155.305(f)(1)(i)). On the date of your application, that was the 2016 FPL, which is $16,020.00 for a two-person household (81 Federal Register 4036).

Cost-Sharing Reductions

Cost-sharing reductions (CSR) are available to a person who (1) is eligible to enroll in a QHP through NYSOH, (2) meets the requirements to receive APTC,

(3) is expected to have an annual household income that does not exceed 250% of the FPL for the first day of the open enrollment period of the benefit year for which coverage is requested, and (4) is enrolled in a silver-level QHP (45 CFR § 155.300(a), 45 CFR § 155.305(g)(1)).

Essential Plan

NYSOH must generally determine an applicant eligible for the Essential Plan, a basic health plan, if the person is (1) a resident of New York State, (2) expects to have a household income between 138% and 200% of the applicable federal poverty level (FPL) or, in the case of an individual who is a lawfully present non-citizen who is ineligible for Medicaid or Child Health Plus as a result of their immigration status, has a household income that is between 0% and 200% of the FPL, (3) is not otherwise eligible for minimum essential coverage except through the individual market, (4) is 64 years old or younger, (5) is a citizen or a lawfully present non-citizen, and (6) is not incarcerated (*see* 42 CFR § 600.305, 42 CFR § 435.603(d)(4), 45 CFR § 155.305(e), NY Social Services Law § 369-gg(3), 42 USC § 18051).

In an analysis of Essential Plan eligibility, the determination is based on the FPL in effect on the first day of the benefit year for which coverage is requested (45 CFR § 155.300(a)). On the date of your application, that was the 2016 FPL, which is $16,020.00 for a two-person household (81 Fed. Reg. 4036.).

The Essential Plan is considered minimum essential coverage therefore, a person who is eligible for the Essential Plan is not eligible for any premium tax credit because they are eligible for minimum essential coverage through the individual market (*see* 26 CFR § 1.36B-2(c)(1), 26 USC § 5000A(f)(1)(C)).

Medicaid

Medicaid can be provided through NYSOH to adults who: (1) are age 19 or older and under age 65, (2) are not pregnant, (3) are not entitled to or enrolled for Medicare benefits under part A or B of title XVIII of the Act, (4) are not otherwise eligible for and enrolled for mandatory coverage under a State's Medicaid State plan in accordance with subpart B of this part, and (5) have a household modified adjusted gross income (MAGI) that is at or below 138% of the FPL for the applicable family size (42 CFR § 435.119(b), 42 CFR § 435.911(b)(1), 42 CFR § 435.603(d)(4)), NY Social Services Law § 366(1)(b)).

In an analysis of Medicaid eligibility, the determination is based on the FPL “for the applicable budget period used to determine an individual's eligibility” (42 CFR § 435.4). On the date of your application, that was the 2017 FPL, which is $16,240.00 for a two-person household (82 Fed. Reg. 8831).

Legal Analysis

The issue under review is whether NYSOH properly determined that you and your spouse were eligible to purchase a QHP only at full cost, as of November 1, 2017.

You are in a two-person household. You expect to file your 2017 income taxes as married and will claim no dependents on that tax return.

According to NYSOH records, on October 4, 2017, NYSOH determined your 2017 estimated annual household income was $64,702.00. You testified that this amount was inaccurate because it was based on the income amounts listed in your 2016 income tax return, which will not equal your 2017 expected annual income.

The October 4, 2017 NYSOH eligibility determination listed your income as follows: taxable interest $14,000.00; deferred compensation distribution $5,300.00; tax exempt interest $3,819.00, ordinary dividends $9,794.00, tax refunds $808.00, capital gain $22,228.00 and qualified dividends $8,753.00 for a total of $64,702.00. NYSOH records reflect that your 2017 estimated annual household income was determined based on your earnings from your 2016 federal income tax return.

On October 5, 2017, NYSOH issued an eligibility determination notice stating that you and your spouse were eligible to enroll in a QHP at full cost based on an annual household income of $64,702.00. The eligibility determination was effective November 1, 2017.

At the December 7, 2017 hearing, you testified that your expected 2017 annual income was as follows: taxable interest $5,000.00; deferred compensation distribution $5,300.00; tax exempt interest $3,819.00, ordinary dividends $9,794.00, tax refunds $11,939.00, capital gain $0.00 and qualified dividends $8,753.00 for a total of $44,605.00.

Since the record now contains a more accurate representation of what your household income was for 2017, the October 5, 2017 eligibility determination notice is RESCINDED and your case is RETURNED to NYSOH to redetermine you and your spouse's eligibility for financial assistance based on a two-person household, with an annual household income of $44,605.00 living in Suffolk County, New York.

Decision

The October 5, 2017 eligibility determination notice is RESCINDED.

Your case is being RETURNED to NYSOH to redetermine you and your spouse's eligibility for financial assistance based on a two-person household, with an annual household income of $44,605.00 living in Suffolk County, New York.

Effective Date of this Decision: January 4, 2018

How this Decision Affects Your Eligibility

Your case is being RETURNED to NYSOH to redetermine you and your spouse's eligibility for financial assistance based on a two-person household, with an annual household income of $44,605.00 living in Suffolk County, New York.

If You Disagree with this Decision (Appeal Rights)

This Decision is final unless you submit an appeal request to U.S. Department of Health and Human Services or bring a lawsuit under New York Civil Practice Law and Rules, Article 78.

You may bring a lawsuit on any Appeals Unit decision in New York State court in accordance with Article 78 of the New York Civil Practice Law and Rules. This must be done within four months after the date of the Decision Date, which appears on the first page of this Decision.

Additionally, Appeals Unit decisions on issues involving eligibility for qualified health plans, advance premium tax credits, and cost-sharing reductions may be appealed to the U.S. Department of Health and Human Services. This must be done within 30 days of the date of the Decision Date, which appears on the first page of this Decision (45 CFR § 155.520(c))

If you wish to be represented by an attorney in bringing an outside appeal and do not know how to go about getting one, you may contact legal resources available to you. You may, for example, contact the local County Bar Association, Legal Aid, or Legal Services.

If You Have Questions about this Decision (Customer Service Resources):

You can contact us in any of the following ways:

- By calling the Customer Service Center at 1-855-355-5777

If you need this information in a language other than English or you need assistance reading this notice, we can help you. Call 1-855-355-5777 (TTY - English: 1-800-662-1220) (TTY – Spanish: 1-877-662-4886).

- By mail at:

  NY State of Health Appeals
  P.O. Box 11729
  Albany, NY 12211

- By fax: 1-855-900-5557

Summary

The October 5, 2017 eligibility determination notice is RESCINDED.

Your case is being RETURNED to NYSOH to redetermine you and your spouse's eligibility for financial assistance based on a two-person household, with an annual household income of $44,605.00 living in Suffolk County, New York.

Legal Authority

We are sending you this notice in accordance with federal regulation 45 CFR § 155.545(a).

A Copy of this Decision Has Been Provided To:

If you need this information in a language other than English or you need assistance reading this notice, we can help you. Call 1-855-355-5777 (TTY - English: 1-800-662-1220) (TTY – Spanish: 1-877-662-4886).

Getting Help in a Language Other than English

This is an important document. If you need help to understand it, please call 1-855-355-5777. We can give you an interpreter for free in the language you speak.

Español (Spanish)

Este es un documento importante. Si necesita ayuda para entenderlo, llame al 1-855-355-5777. Le proporcionaremos un intérprete sin ningún costo.

中文 (Traditional Chinese)

這是重要的文件。 如果您需要獲得關於瞭解文件內容方面的協助，請致電 1-855-355-5777。我們可以為您免費提供您所使用語言的翻譯人員。

Kreyòl Ayisyen (Haitian Creole)

Sa a se yon dokiman ki enpòtan. Si ou bezwen èd pou konprann li, tanpri rele nimewo 1-855-355-5777. Nou kapab ba ou yon entèprèt gratis nan lang ou pale a.

中文 (Simplified Chinese)

这是一份重要的文件。如果您需要帮助理解此文件，请打电话至 1-855-355-5777。我们可以为您免费提供相应语种的口译服务。

Italiano (Italian)

Questo è un documento importante. Per qualsiasi chiarimento può chiamare il numero 1-855-355-5777. Possiamo metterle a disposizione un interprete nella sua lingua.

한국어 (Korean)

중요한 서류입니다. 이해하는 데 도움이 필요하시면 1-855-355-5777 번으로 연락해 주십시오. 귀하의 언어에 대한 무료 통역 서비스가 제공됩니다.

Русский (Russian)

Это важный документ. Если Вам нужна помощь для понимания этого документа, позвоните по телефону 1-855-355-5777. Мы можем бесплатно предоставить Вам переводчика Вашего языка.

العربية (Arabic)

هذه وثيقة مهمة. إذا كنت بحاجة إلى مساعدة لفهم محتواها، يُرجى الاتصال بالرقم 1-855-355-5777. يُمكننا توفير مترجم فوري لك باللغة التي تتحدثها مجانًا.

বাংলা (Bengali)

এটি এক গুরুত্বপূর্ণ নথি। এটি বুঝতে আপনার যদি সাহায্যের প্রয়োজন হয় তাহলে, অনুগ্রহ করে 1-855-355-5777 নম্বরে কল করুন। আপনি যে ভাষায় কথা বলেন বিনামূল্যে আমরা আপনাকে একজন দোভাষী দিতে পারি।

If you need this information in a language other than English or you need assistance reading this notice, we can help you. Call 1-855-355-5777 (TTY - English: 1-800-662-1220) (TTY – Spanish: 1-877-662-4886).

Français (French)

Ceci est un document important. Si vous avez besoin d'aide pour en comprendre le contenu, appelez le 1-855-355-5777. Nous pouvons mettre gratuitement à votre disposition un interprète dans votre langue.

हिंदी (Hindi)

यह एक महत्वपूर्ण दस्तावेज़ है। अगर आपको इसे समझने में सहायता चाहिए, तो कृपया 1-855-355-5777 पर कॉल करें। हम आपकी भाषा बोलने वाला एक दुभाषिया निःशुल्क उपलब्ध करवा सकते हैं।

日本語 (Japanese)

これは重要な書類です。理解するために支援が必要な場合は、1-855-355-5777 にお電話ください。通訳を無料で提供いたします。

नेपाली (Nepali)

यो एउटा महत्त्वपूर्ण कागजात हो। यसलाई बुझ्न तपाईंलाई मद्दत चाहिन्छ भने, कृपया 1-855-355-5777 मा फोन गर्नुहोस्। हामीले तपाईंले बोल्ने भाषामा तपाईंलाई निःशुल्क दोभाषे उपलब्ध गराउन सक्छौं।

Polski (Polish)

To jest ważny dokument. W przypadku konieczności skorzystania z pomocy w celu zrozumienia jego treści należy zadzwonić pod numer 1-855-355-5777. Istnieje możliwość uzyskania bezpłatnej usługi tłumacza języka, którym się posługujesz.

Twi (Twi)

Krataa yi yɛ tow krataa a ho hia. Sɛ wo hia ɛho nkyerɛkyerɛmu a, yɛ srɛ wo, frɛ 1-855-355-5777. yƐbƐtumi ama wo obi a ɔkyerƐ kasa a woka no ase ama wo kwa a wontua hwee.

اردو (Urdu)

یہ ایک اہم دستاویز ہے۔ اگر آپ کو اسے سمجھنے کے لیے مدد کی ضرورت ہے تو براہ کرم1-855-355-5777 پر کال کریں۔ ہم آپ کو آپ کی مادری زبان میں ایک مفت مترجم فراہم کر سکتے ہیں۔

Tiếng Việt (Vietnamese)

Đây là tài liệu quan trọng. Nếu quý vị cần trợ giúp để hiểu tài liệu này, vui lòng gọi 1-855-355-5777. Chúng tôi có thể cung cấp thông dịch viên miễn phí nói ngôn ngữ của quý vị.

אידיש (Yiddish)

דאס איז א וויכטיגער דאקומענט. אויב איר דארפט הילף עס צו פארשטיין, ביטע רופט 1-855-355-5777. מיר קענען אייך געבן א דאלמעטשער פריי פון אפצאל אין די שפראך וואס איר רעדט.

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